index, plus a per diem payment for the hospital's pass-through costs, direct medical education and capital payment amounts.

9. **Transfer Per Diem Payments**

a. **Transfer Between Hospitals**

In general, payments for patients transferred from one acute hospital to another will be made on a transfer per diem basis (capped at the per discharge payment) for the hospital that is transferring the patient. The amount of the transfer per diem payment is equal to the RY99 statewide average payment amount per day, multiplied by the transferring hospital's RY99 Medicaid casemix index and wage area index, plus pass-through, direct medical education, and capital per diem payments.

To derive the standard payment amount per day for transfer patients, the RY99 statewide average payment amount per discharge of $2,810.71 is divided by the FY95 average all-payer Medicaid length of stay of 5.0931 days, which equals $551.88. The hospital-specific capital, direct medical education, and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay from casemix data.

In general, the hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in Sections IV.B.2-5, if the patient is discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital will be paid at the hospital-specific transfer per diem rate, capped at the hospital-specific per discharge amount. Additionally, "back transferring" hospitals will be eligible for outlier payments specified in Section IV.B.8.

Refer to matrices attached as **Exhibit 3** for a review of transfer scenarios and corresponding payment mechanisms involving MH/SAP-eligible and MH/SAP-ineligible recipients in MH/SAP contractor network and non-network hospitals.

b. **Transfers within a Hospital**

In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be reimbursed on a per diem basis. This section shall outline reimbursement under some specific transfer circumstances. For a complete review of reimbursement under transferring circumstances involving MH/SAP-eligible recipients and MH/SAP-ineligible recipients in the MH/SAP network and non-network hospitals, refer to the matrices attached as **Exhibit 3.**

(1) **Transfer to/from a Chronic or Rehabilitation Unit within the Same Hospital**

If a patient is transferred from an acute bed to a chronic or rehabilitation unit in the same hospital, the transfer is considered a discharge. The Division will pay the hospital-specific SPAD for the portion of the stay before the patient is transferred to the chronic or rehabilitation unit.

(2) Medicaid Payments for Newly Eligible Recipients or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible or other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay will be paid at the transfer per diem rate, up to the hospital-specific SPAD, or, if the patient is at the administrative day level of care, at the AD per diem rate.

(3) Admissions Involving One-Day Length of Stay Following Surgical Services

If a patient who requires hospital inpatient services is admitted for a one-day stay following outpatient surgery, the hospital shall be paid at the transfer per diem rate instead of the hospital-specific SPAD.

(4) Transfer between a Distinct Part Psychiatric Unit and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a distinct part psychiatric unit and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, MH/SAP network or non-network hospital, or the type of service provided. Please refer to the appropriate matrix in Exhibit 3 for reimbursement under specific transfer circumstances involving psychiatric stays.

(5) Change of Managed Care Status during a Psychiatric or Substance Abuse Hospitalization

(a) Payments to hospitals <u>without</u> network provider agreements with the Division's MH/SAP Contractor

When a recipient becomes assigned to the MH/SAP during a non-emergency or emergency mental health or substance abuse admission at a Non-Network Hospital, the portion of the hospital stay during which the recipient is enrolled in the MH/SAP shall be paid by the Division's MH/SAP Contractor provided that the hospital complies with the MH/SAP contractor's service authorization and billing policies and procedures. The portion of

the hospital stay during which the recipient was not enrolled in the MH/SAP will be paid by the Division at the psychiatric per diem rate for mental health services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

(b) Payments to hospitals with network provider agreements with the Division's MH/SA Contractor

When a patient enrolls in the MH/SAP during an emergency or non-emergency mental health or substance abuse hospital admission, the portion of the hospital stay during which the recipient was enrolled in the MH/SAP shall be paid by the Division's MH/SAP contractor at the per diem rates agreed upon by the hospital and the MH/SAP contractor provided that the hospital complies with the MH/SAP contractor's service authorization and billing policies and procedures.

The portion of the hospital stay during which the recipient was not enrolled in the MH/SAP will be paid by the Division at the psychiatric per diem for mental health services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

10. Physician Payment

For physician services provided by hospital-based physicians or hospital-based entities to Medicaid inpatients, the hospital will be reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 et seq. Such reimbursement shall be at the lower of the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00 (Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)[1], or the hospital's usual and customary charge.

Hospitals will be reimbursed for such physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the Direct Medical Education (DME) portion of the SPAD payment and, as such, are not reimbursable separately. Hospitals will not be reimbursed separately from the SPAD and per diem payments for professional fees for practitioners other than hospital-based physicians.

[1] The regulations referred to in this paragraph are voluminous, and will be provided upon request.

Hospitals shall not be reimbursed for inpatient physician services provided by community-based physicians.

11. **Payments for Administrative Days**

Payments for administrative days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals.

- The AD rate is comprised of a base per diem payment and an ancillary add-on.

- The base per diem payment is the average Medicaid nursing home rate in state fiscal year 1995 for acuity categories H to L. This base rate is $75.83. The ancillary add-on ratios of 0.0665 and 0.2969, for Medicaid/Medicare Part B eligible patients and Medicaid-only patients, respectively, were maintained for the RY99 RFA. The resulting AD rates (base and ancillary) were then updated for inflation using the update factors 3.16% for RY96; 2.38% for RY97; 2.14% for RY98; and 1.9% for RY99. The resulting AD rates for RY98 are $84.17 for Medicare/Medicaid Part B eligible patients and $135.75 for Medicaid-only eligible recipients.

A hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD where the patient fluctuates between acute status and AD status; the hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for outlier days, as described above.

12. **Infant and Pediatric Outlier Payment Adjustments**

a. **Infant Outlier Payment Adjustment**

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to acute hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths-of-stay. Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.05(2)(k) (attached as Exhibit 4).

b. **Pediatric Outlier Payment Adjustment**

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to acute hospitals for inpatient hospital services furnished to children greater than one year of age and less than six years of age if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923(a) of the Social Security Act. (See Federally-Mandated Disproportionate Share Adjustment, Section IV.D.2 for qualifying hospitals.) Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.05(2)(k).

13. Rehabilitation Unit Services in Acute Hospitals

A per diem rate for rehabilitation services provided at an acute hospital shall apply only to acute hospital rehabilitation units operating at public service hospitals in order to meet any remaining service needs following closure of a public rehabilitation hospital.

The per diem rate for such rehabilitation services will equal the average MassHealth FY97 rehabilitation hospital rate adjusted for inflation. This rate represents the average MassHealth FY97 rehabilitation hospital rate, weighted by volume of days, after removing the two lowest rate-rehabilitation hospitals from the average. Acute hospital administrative day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care.

14. Emergency or Outpatient Department Visits which Result in an Inpatient Admission

Services provided to a recipient in an acute hospital outpatient or Emergency Department on the same day as an inpatient admission of that patient to the same hospital are reimbursed through the inpatient payment methodology only.

C. REIMBURSEMENT FOR UNIQUE CIRCUMSTANCES

1. Sole Community Hospital

The standard inpatient payment amount for a sole community hospital (as defined in Section II) shall be equal to the sum of:

> 95% of the hospital's FY95 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY99 pass-through amount per discharge, direct medical education amount per discharge, and the capital amount per discharge.

Derivation of RY99 per discharge costs is described in Subsection IV.B.2.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payer casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1997 through May 31, 1998.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, an adjustment of 2.14% was made to reflect inflation between RY97 and RY98, and an adjustment of 1.9% was made to reflect inflation between RY98 and RY99.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as sole community hospitals shall be determined by the Division.

2. Specialty Hospitals and Hospitals with Pediatric Specialty Units

The standard inpatient payment amount for specialty hospitals and hospitals with pediatric specialty units (as defined in Section II) shall be equal to the sum of:

> 95% of the hospital's FY95 cost per discharge, with the FY95 cost per discharge capped at 15% over the RY96 contract's FY90 base cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY99 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of RY99 per discharge costs is described in Subsection IV.B.2.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payer casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1997 through May 31, 1998.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, 2.14% to reflect inflation between RY97 and RY98, and 1.9% to reflect inflation between RY98 and RY99.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as specialty hospitals and hospitals with pediatric specialty units shall be determined by the Division.

3. Public Service Hospital Providers

Public Service Hospitals shall be reimbursed as follows. For public service hospitals that merged on or after October 1, 1994, this methodology shall apply only to those hospital costs that the Division determines to be attributable to that entity which had public service hospital status prior to the merger. The standard inpatient payment amount for public service hospital providers (as defined in Section II) shall be equal to the sum of:

> 95% of the hospital's FY95 cost per discharge, with the FY95 cost per discharge capped at 15% over the RY96 contract's FY90 base cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY99 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of RY99 per discharge costs is described in Section IV.B.2.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payor casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1997 through May 31, 1998.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, 2.14% to reflect inflation between RY97 and RY98, and 1.9% to reflect inflation between RY98 and RY99.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. Non-Profit Teaching Hospitals Affiliated with a Commonwealth-Owned Medical School

a. Subject to Section IV.C.4.b, the inpatient payment amount for non-psychiatric

admissions at non-profit acute care teaching hospitals affiliated with a state-owned university medical school shall be equal to the hospital's RY99 cost per discharge calculated as follows:

The data used for this payment will be from the most recent submission of the hospital's or predecessor hospitals' DHCFP-403 report(s). Total hospital-specific inpatient non-psychiatric charges are multiplied by the hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using DHCFP-403, schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the hospital-specific non-psychiatric Medicaid discharges to the total hospital non-psychiatric discharges to yield the Medicaid inpatient non-psychiatric cost. The Medicaid inpatient non-psychiatric cost is then divided by the number of Medicaid non-psychiatric discharges to calculate the Medicaid cost per discharge. This Medicaid cost per discharge is multiplied by the inflation rates for those years between the year of the cost report and the current rate year, as set forth in Section IV.B.2.a.

b. Any payment amount in excess of amounts which would otherwise be due any state-owned teaching hospital pursuant to Section IV.B is subject to specific legislative appropriation and intergovernmental transfer.

D. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments

MassHealth will assist hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, MassHealth will make an additional payment to hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only hospitals that have an executed contract with the Division, pursuant to the RY99 RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. MassHealth-participating hospitals may qualify for adjustments and may receive them at any time throughout the rate year. If a hospital's RFA contract is terminated, its adjustment shall be prorated for the portion of RY99 during which it had a contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible hospitals. The following describes how hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

In accordance with federal and state law, hospitals must have a Medicaid inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to DHCFP regulation at 114.1 CMR 36.07 (1) (attached as Exhibit 5). Also, the total amount of DSH payment adjustments awarded to any hospital shall not exceed the costs incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third-party coverage, less payments received by the hospital for medical assistance and by uninsured patients ("unreimbursed costs"), pursuant to 42 U.S.C. §1396r-4(g).

When a hospital applies to participate in MassHealth, its eligibility and the amount of its adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications. Therefore, some disproportionate share adjustments may require recalculation pursuant to DHCFP regulations set forth at 114.1 CMR 36.07 (attached as Exhibit 4). Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within Section IV.D., a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2).

1. **High Public Payer Hospitals: Sixty-Three Percent Hospitals**
(Total Annual Funding: $11,700,000)

The eligibility criteria and payment formula for this DSH classification are specified by regulations of the Division of Health Care Finance and Policy (DHCFP) promulgated in accordance with M.G.L. c.118G § 11(a) (See 114.1 CMR 36.07(2) (attached as Exhibit 4)), and pursuant to its Interagency Service Agreement (ISA) with the Division. For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payer mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers and free care. (See M.G.L. c. 118G §1.)

2. **Basic Federally Mandated Disproportionate Share Adjustment**
(Total Annual Funding: $200,000)

The eligibility criteria and payment formula for this DSH classification are described regulations promulgated by DHCFP, pursuant to its ISA with the Division and in accordance with the minimum requirements of 42 U.S.C. §1396r-4. (See 114.1 CMR 36.07(3) (attached as Exhibit 4).)

3. **Disproportionate Share Adjustment for Safety Net Providers**

The eligibility criteria and payment formulas for this DSH classification are specified in DHCFP regulations, pursuant to its ISA with the Division. (See 114.1 CMR 36.07 (4) (attached as Exhibit 4). Payments will be made by the Division to eligible hospitals in accordance with their agreements with the Division concerning intergovernmental transfer of funds.

4. **Uncompensated Care Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in DHCFP regulations pursuant to M.G.L. c.118G §18. The payment amounts for eligible hospitals participating in the free care pool are determined and paid by DHCFP in accordance with its regulations at 114.6 CMR 7.00 (attached as Exhibit 5) and its ISA with the Division.

5. **Public Health Substance Abuse Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000 (attached as Exhibit 6) and DPH's ISA with the Division. The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are

determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 (attached as Exhibit 6) and DPH's ISA with the Division.

6. Children's Medical Security Plan Disproportionate Share Adjustment

Title XIX hospitals eligible for this adjustment are those that provide hospital services to low-income children who are uninsured, not enrolled in the MassHealth program and eligible for the Children's Medical Security Program, established by M.G.L. c. 111, § 24F and 24G (attached as Exhibit 7). The payment amount for eligible hospitals receiving payments, pursuant to the Children's Medical Security Plan, are determined and paid on a periodic basis by the Department of Public Health under an ISA with the Division and in accordance with M.G.L. c.111 § 24F and 24G.

7. Disproportionate Share Adjustment for Non-Profit Acute Care Teaching Hospitals Affiliated with a State-Owned University Medical School

a. Eligibility

The Division shall determine, effective April 1, 1998, a disproportionate share payment adjustment for non-profit, acute care teaching hospitals that have an affiliation with a state-owned university medical school. In order to be eligible for this disproportionate share payment, the non-profit acute care teaching hospital must:

(1) enter into an agreement with a state-owned university medical school to purchase from the medical school (a) such medical education activities as are described on Exhibit 8 attached hereto, (b) clinical support, and (c) clinical activities (collectively, "the purchased services");
(2) pay the state-owned university medical school for the purchased services in an amount which is the lower of (x) the medical school's costs for such purchased services or (y) an amount equal to the difference between (a) the aggregate reimbursement paid to the hospital by the Division in accordance with Section IV.C.4 above, Section IV.C.2 of Attachment 4.19B(1), and this Section IV.D.7; and (b) the reimbursement which would otherwise have been paid to the hospital by the Division if the hospital were not affiliated with a state-owned university medical school;
(3) have a common mission as established by state law, with the state-owned university medical school dedicated to train physicians, nurses, and allied health professionals according to high professional ethical standards and to provide high quality health care services;
(4) be the subject of an appropriation to the Division which

requires the state-owned university medical school to make an intergovernmental funds transfer in an amount equal to 50% of the appropriated amount;

and the public entity (the state-owned university medical school) obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the appropriation referenced in clause (4) above.

b. Payment Amount

The Division provides eligible hospitals with instructions relative to the filing of cost reports necessary for calculation of the adjustment and calculates an adjustment for eligible hospitals. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. For purposes of this adjustment, the Division shall deem the costs of the medical and paramedical educational services specified in Exhibit 8 to constitute costs of services provided by the hospital to patients eligible for medical assistance under Title XIX, or to low-income patients. This disproportionate share adjustment will reimburse only those costs which have not otherwise been reimbursed and will be paid subject to the availability of federal financial participation.

E. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA).

If any portion of the reimbursement methodology is not approved by HCFA, the Division may recoup any payment made to a hospital in excess of the approved methodology.

F. Treatment of Reimbursement for Recipients in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, reimbursement to participating hospitals for services provided to MassHealth recipients who are at acute inpatient status prior to October 1, 1998 and who remain at acute inpatient status on or after October 1, 1998 shall continue to be reimbursed at the hospital's RY98 rates. Reimbursement to participating hospitals for services provided to Medicaid recipients who are admitted on or after October 1, 1998 shall be reimbursed at the RY99 hospital rates.

G. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

H. Errors in Calculation of Pass-through Amounts, Direct Medical Education Cost or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY99 pass-through costs, direct medical education costs or capital costs, resulting in an amount not consistent with the methodology, a correction can be made at any time during RY99, upon agreement by both parties. Such corrections will be made to the final hospital-specific rate retroactive to October 1, 1998 for RY99 rates, but will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs. Hospitals must submit copies of the relevant report as referenced in Section IV.B.1, highlighting items found to be in error, to Kiki Feldmar, Division of Medical Assistance, Benefit-Services, 5th floor, 600 Washington Street, Boston, MA 02111 during the term of the contract to initiate a correction.

I. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining hospitals' rates. Such rates may, in the Division's sole discretion, affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

J. Hospital Change of Ownership

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the hospital during the effective period of the RFA, the Division, in its sole discretion, shall determine, on a case-by-case basis (1) whether the hospital qualifies for reimbursement under the is RFA, and, if so, (2) the appropriate rate of such reimbursement. The Division's determination shall be based on the totality of the circumstances. Any such rate may, in the Division's sole discretion, affect computation of the statewide average payment amount and/or any efficiency standard.

TN 98-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 1:
130 CMR 415.415
130 CMR 415.416
130 CMR 450.204

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

(1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.

(2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).

(3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.

(4) A recipient with lead poisoning is awaiting deleading of his or her residence.

(5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

(6)recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

(7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.

(8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:

(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies (respiratory, speech, physical, occupational, etc.);
(f) insertion, irrigation, and replacement of catheters; and
(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

(A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;

(B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or

(C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

415.417: Notification of Denial, Reconsideration, and Appeals

(A) Notification of Denial. The Division or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines as part of a concurrent review that the hospital admission or stay, or any part thereof, is not medically or administratively necessary. The Division or its agent shall notify the hospital and the recipient's attending physician whenever it determines as part of a concurrent or retrospective review that the hospital stay is or was no longer medically necessary but is or was administratively necessary. The Division or its agent shall notify the hospital and the recipient whenever it determines as part of a concurrent review that a hospital stay is no longer administratively necessary due to the refusal of an appropriate placement.

(B) Reconsideration. An agent of the Division under 130 CMR 415.000 may provide an opportunity for reconsideration of a determination made by that agent. If a reconsideration is available, notice of the agent's determination will include written notice of: the right to a reconsideration; the time within and manner in which a reconsideration must be requested; and the time within which a decision will be rendered. A hospital, a physician, or a recipient entitled to have a determination reconsidered must request and have a reconsideration determination given before requesting a hearing under 130 CMR 415.417(C).

450.202: continued

(C) Violations of the regulations set forth in 130 CMR 450.202(A) and (B) may result in administrative action, referral to the Massachusetts Commission against Discrimination, or referral to the U.S. Department of Health and Human Services, or any combination of these.

450.203: Payment in Full

Federal and Massachusetts law require that participation in the Medical Assistance Program be limited to providers that agree to accept, as payment in full, the amounts paid in accordance with the applicable fees and rates or amounts established under a provider agreement or regulations applicable to Medical Assistance reimbursement (*see* 42 CFR 447.15, M.G.L. c. 118E, § 18, and M.G.L. c. 6A, § 35). No provider shall solicit, charge, receive, or accept any money, gift, or other consideration from a recipient, or from any other person, for any item of medical service for which payment is available under the Medical Assistance Program, in addition to, in lieu of, or as an advance or deposit against the amounts paid or payable by the Division for such item, except to the extent that the regulations specifically require or permit contribution or supplementation by the recipient or by a health insurer. (For instances of retroactive recipient eligibility, *see* 130 CMR 450.311(B)).

450.204: Medical Necessity

(A) A provider may furnish or prescribe medical services to a recipient, or cause a recipient to be admitted to an inpatient facility, only when, and to the extent, medically necessary. A service is "medically necessary" if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no comparable medical service or site of service available or suitable for the recipient requesting the service that is more conservative or less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality. Those records shall be made available to the Division upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(B) A provider's opinion or clinical determination that a service is not medically necessary shall not constitute an action of the Division.

450.205: Recordkeeping and Disclosure

(A) Documentation to substantiate the furnishing of services reimbursable under the Medical Assistance Program is a condition of reimbursement for such services. All providers must keep such records as are necessary to disclose fully the extent of services furnished to recipients and must furnish to the Division and the Medicaid Fraud Control Unit on request such information and any other information regarding payments claimed by the provider for furnishing services (see 42 U.S.C. 1396a(a)(27) and the regulations thereunder). In addition to medical records, the provider must retain all financial records, including, but not limited to, a provider's audited financial statements, auditors' workpapers, explanation of benefits from insurance companies and HMOs, and any calculations or workpapers used to derive reserves or estimates due to the Division. All records described in 130 CMR 450.205 shall be retained for at least four years after the date of medical services for which claims are made or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever time period is longer. Institutional providers shall, in addition, furnish on request all records maintained by or within the institution regarding services furnished to recipients by other providers. Pharmacy providers must, in addition, retain photocopies of the temporary MassHealth cards referenced when filling prescriptions, if applicable, and produce a copy of the card on request.